Patient History Questionnaire

Name _____ Birth date _____

Name of referring physician _____ Physician phone _____

Physician Address _____ Date of last eye exam _____

History of Present Illness (elements):

____ Location ____ Quality ____ Severity ____ Modifying Factors

____ Timing ____ Duration ____ Context ____ Associated Signs & Symptoms

REVIEW OF SYSTEMS

Do you currently have any problems in the following areas? If "yes," provide information.

	YES	NO	Explanation of Problem
Constitutional Symptoms	☐	☐	_____
Fever	☐	☐	_____
Weight loss	☐	☐	_____
Other	☐	☐	_____
Eyes	☐	☐	_____
Loss of vision	☐	☐	_____
Blurred vision	☐	☐	_____
Distorted vision (halos)	☐	☐	_____
Loss of side vision	☐	☐	_____
Double vision	☐	☐	_____
Dryness	☐	☐	_____
Mucous discharge	☐	☐	_____
Redness	☐	☐	_____
Sandy or gritty feeling	☐	☐	_____
Itching	☐	☐	_____
Burning	☐	☐	_____
Foreign body sensation	☐	☐	_____
Excess tearing/watering	☐	☐	_____
Occasional tearing	☐	☐	_____
Glare/Light sensitivity	☐	☐	_____
Eye pain or soreness	☐	☐	_____
Chronic infection of eye or lid	☐	☐	_____
Sties, Chalazion	☐	☐	_____
Fluctuating visual acuity	☐	☐	_____
Tired eyes	☐	☐	_____

(continued)

	YES	NO	Explanation of Problem
Ears, nose, mouth, throat	☐	☐	
Sinus congestion	☐	☐	
Runny nose	☐	☐	
Post-nasal drip	☐	☐	
Chronic cough	☐	☐	
Dry throat/mouth	☐	☐	
Cardiovascular (heart/blood vessels)	☐	☐	
Respiratory (lungs/breathing)	☐	☐	
Chronic bronchitis	☐	☐	
Gastrointestinal (stomach/intestines)	☐	☐	
Genitourinary (genitals/kidney/bladder)	☐	☐	
Musculoskeletal	☐	☐	
Muscle	☐	☐	
Joint	☐	☐	
Integumentary (skin and/or breast)	☐	☐	
Neurological	☐	☐	
Psychiatric	☐	☐	
Endocrin	☐	☐	
Hematologic/Lymphatic	☐	☐	
Blood	☐	☐	
Lymph nodes	☐	☐	
Swelling	☐	☐	
Allergic/Immunologic	☐	☐	
Head allergy symptoms	☐	☐	
Seasonal allergies	☐	☐	
Hay fever symptoms	☐	☐	
Are immunizations up to date?	Y	N	

PAST HISTORY

List any medications you currently take _____

_____

List all major illnesses and injuries _____

_____

_____

(continued)

List any surgeries you have had _____

_____

_____

Have you had crossed eyes, lazy eye, drooping eyelid, prominent eyes?

_____

_____

Do you have allergies to any medications? ☐ YES ☐ NO

If YES, list medications _____

_____

_____

FAMILY HISTORY

DISEASE	YES	NO	Relationship to Patient
Blindness	☐	☐	_____
Cataract	☐	☐	_____
Glaucoma	☐	☐	_____
Macular degeneration	☐	☐	_____
Retinal detachment	☐	☐	_____
Arthritis	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Heart attacks	☐	☐	_____
High blood pressure	☐	☐	_____
Kidney disease	☐	☐	_____
Lupus	☐	☐	_____
Sjogrens Syndrome	☐	☐	_____
Stroke	☐	☐	_____
Thyroid disease	☐	☐	_____
Tuberculosis	☐	☐	_____
Other	☐	☐	_____

(continued)

SOCIAL HISTORY

MARITAL STATUS: S M W D SEP

Current occupation _____

Do you drive? ☐ YES ☐ NO

Do you have visual difficulty when driving? ☐ YES ☐ NO

Do you have problems with night vision? ☐ YES ☐ NO

Have you ever tried to wear contacts? ☐ YES ☐ NO

Do you currently wear glasses? ☐ YES ☐ NO

If YES, how long have you had the current prescription? _____

Do you drink alcohol? ☐ YES ☐ NO

If YES, how often? _____

Do you smoke? ☐ YES ☐ NO

If YES, how many packs a day _____

Have you ever had a blood transfusion? ☐ YES ☐ NO

Have you ever been in intimate contact with a person who had a sexually transmitted disease? ☐ YES ☐ NO

History reviewed. ☐ No changes ☐ Additions as noted above

Physician's signature: _____ Date: _____